MDR Tracking Number: M5-04-0593-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on October 27, 2003.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with § 133.308(r)(9**),** the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $650** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The office visits, myofascial release, therapeutic procedures, neuromuscular reeducation, ultrasound therapy, supplies, and range of motion measurement were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

This findings and decision is hereby issued this 20th day of January 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 12/20/02 through 01/31/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 20th day of January 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

PR/pr

January 14, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-0593-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in physical medicine and rehabilitation. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History
This case concerns a female who sustained a work related injury on ___. The patient reported that while at work she injured her right shoulder when she attempted to break her fall from a chair. The diagnoses for this patient have included right shoulder full thickness supraspinatus tendon tear, labrum tear, bursitis and AC joint arthrosis. On 8/29/02 the patient underwent arthroscopic surgery of the right shoulder. Treatment for this patient's condition has included physical therapy consisting of joint mobilization, scar tissue and myofascial release, electrical stimulation, ultrasound, joint mobilization, and therapeutic exercises for passive range of motion.

Requested Services
Ovs, myofascial release, therapeutic procedures, neuromuscular reeducation, ultrasound therapy, supplies, range of motion measurement from 12/20/02 through 1/31/03.

Decision
The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision
The ___ chiropractor reviewer noted that this case concerns a female who sustained a work related injury to her right shoulder on ___. The ___ physician reviewer indicated that the patient was diagnosed a rotator cuff injury and underwent surgical repair. The ___ physician reviewer explained that the patient received physical therapy from 8/31/02 through 12/18/02 with gradual improvement in right shoulder range of motion and motor strength.

The ___ physician reviewer also explained that there was no plateauing in the patient's condition noted. The ___ physician reviewer noted that the patient continued to complain of pain and not full active use of her right shoulder. The ___ physician reviewer indicted that continued improvement is expected with functional range of motion in right shoulder and skilled physical therapy was medically necessary to advance/improve the patient's range of motion/strength and decrease pain. The ___ physician reviewer explained that through myofascial release techniques, joint mobilization, ultrasound and electrical stimulation are all therapeutic exercises that would facilitate this improvement. Therefore, the ___ physician consultant concluded that the ovs, myofascial release, therapeutic procedures, neuromuscular reeducation, ultrasound therapy, supplies, range of motion measurement from 12/20/02 through 1/31/03 were medically necessary to treat this patient's condition.

Sincerely,